COL Michael Chesser, MD, USAF; Hamed Abbaszadegan, MD; and Shak Rehman, MD

Using an Incident Command System Model for Initial Response to an Administrative Crisis at the Phoenix VA Health Care System

On April 9, 2014, allegations were made relating to delays experienced by patients accessing care at the Phoenix VA Health Care System (PVAHCS). After an in-depth investigation, multiple administrative problems were discovered related to scheduling processes at PVAHCS as well as many other VA facilities across the country. In Phoenix, there were 1,400 patients on the official electronic waiting list (EWL) in addition to 1,700 patients who had requested care but were not on any official waiting list.[1]

The following is a description of the use of an Incident Command System (ICS) model to provide care for these veterans in the face of an existing lack of capacity to do so. This is written from the perspective of frontline physicians representing hospital medicine, the emergency department, and primary care. The authors' views do not necessarily reflect the official position of the VA or PVAHCS.

Under direction of the President, the VA crafted the official response to meet the needs of veterans awaiting care. The program, called the Accelerating Care Initiative (ACI), was launched on May 21, 2014. With the cooperation of the White House, the VA brought to bear substantial resources to enable PVAHCS to accomplish the task with an "all-hands-on-deck" approach. These resources included the Disaster Emergency Medical Personnel System (DEMPS), Traveling Nurse Corps (TNC), and the VA Locum Tenens program.

This situation was unprecedented, and an administrative framework was needed to organize and manage the extra personnel and resources involved in the response. The decision was made to use the ICS to achieve this aim. Most people involved in health care administration have been exposed to ICS concepts but are not accustomed to approaching an administrative problem the way emergency managers would respond to a natural disaster, such as a flood or hurricane.

According to the Federal Emergency Management Agency, ICS is "a standardized on-scene emergency management construct."[2] Incident Command System combines resources and people under a common organizational structure, using a common terminology to facilitate cooperation between any and all entities that may be involved in an incident. It is a modular concept and designed to be adaptable and scalable from isolated local events, such as a traffic accident, to regional catastrophes such as a category 5 hurricane. Incident Command System was developed in the 1970s, but it has become the standard approach for government agencies, law enforcement, first responders, and the military.

The PVAHCS adopted an ICS framework, and the chief of staff (COS) took on the incident commander role full time. The deputy assumed all other COS duties related to hospital operations. Phoenix VA Health Care System used the VA national call center to rapidly contact patients awaiting care and established the other standard ICS branches with Operations, Planning, Logistics, and Finance/Administration with appropriate task forces underneath each department. Within

Dr. Chesser is a hospitalist, **Dr. Abbaszadegan** is the chief health informatics officer and an emergency department physician, and **Dr. Rehman** is the associate chief of staff for education and a primary care physician, all at the Phoenix VA Health Care System in Arizona. Also, Dr. Chesser is a clinical assistant professor of internal medicine, Dr. Abbaszadegan is a clinical assistant professor of internal medicine and biomedical informatics, and Dr. Rehman is a professor of internal medicine, all at the University of Arizona College of Medicine—Phoenix.

Operations, PVAHCS established task forces for the primary care, medical specialty care, surgical specialty care, and mental health departments.

Efficient command, control, and communication was facilitated by having twice-daily huddles with key staff members for 20 to 30 minutes to share updates and refine operational goals. This worked well and provided the situational awareness for our incident commander to rapidly channel situation reports (SITREPS) to the VA Secretary's office in Washington without drawing focus away from creating solutions. As a midsize facility that lacks certain specialized medical and surgical services, PVAHCS already had an established system for referring veterans for these services. This enabled PVAHCS to use these channels to provide medical and surgical specialty care where demand exceeded capacity to schedule within a reasonable time frame.

Federal law, at the time, severely limited the ability of PVAHCS to outsource primary care in this fashion, which required finding new ways to create additional capacity. This was a major operational challenge due to very limited physical space as well as an insufficient number of primary care and administrative support staff. The PVAHCS made the equivalent of 5 new primary care teams operational with rotating volunteers from other VAs and our preexisting DEMPS, Locum Tenens, and TNC programs.

Medical subspecialty clinics within the primary care area were promptly moved to create space for the new primary care teams. To create this additional space, PVAHCS postponed a planned expansion of a community living center in the main hospital building complex. While PVAHCS was standing up the ICS, VA facilities from other regions loaned 3 mobile medical units. These vehicles included fully capable examination tables and telehealth capability and were used for intake appointments, new unassigned patients, and as administrative space.

In August 2014, the Veterans Choice Act (VCA) allowed veterans to access care from non-VA providers. Eligibility was based on the distance a veteran lived from a VA facility or the inability to be seen within a specified time period. The VCA provided PVACHS with an additional tool to meet veterans' care needs as it increased the hiring of permanent staff. After about 3 months, PVAHCS succeeded in contacting > 6,000 veterans and providing > 3,200 veterans with appointments at the either PVAHCS or local civilian partners.

Despite the initial successes, the preliminary gains in patient access at PVAHCS will not be sustainable, and wait times will not decrease substantially without increased permanent staff and further improvements in both the facility and its processes. Although these improvements are a priority, progress has been slow.

Efforts are underway to enhance operational integration between providers, nursing, and administrative support personnel. Congress has renewed its support of a larger and more functional health care center along with the addition of 2 more clinics within the metro Phoenix area. The PVAHCS has since stood down the ICS and ACI operations and transferred these operations to a newly created Patient Flow Committee. This group is chaired by the COS and meets monthly to supervise process improvement teams using lean modalities to address issues creating excessive waits or delays in patient care throughout the facility.

This access to care crisis was exacerbated by intense media and political attention. Further disarray resulted from the abrupt loss of several senior executives at PVAHCS—all the way up to former VA Secretary Eric K. Shinseki. Use of the ICS was highly effective in providing the necessary organizational structure for key staff to focus on solving the immediate problems locally while managing external resources that were in constant flux. The authors strongly recommend consideration of the ICS as a management framework to tackle similar problems. ●

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REFERENCES

1. VA Office of Inspector General. Veterans Health Administration Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System. U.S. Department of Veterans Affairs Website. http://www.va.gov/oig/pubs/VAOIG-14-02603-178.pdf. Published May 28, 2014. Accessed November 16, 2015.
2. U.S. Department of Homeland Security, Federal Emergency Management Agency. Developing and Maintaining Emergency Operations Plans. Comprehensive Preparedness Guide 101, Version 2.0. Federal Emergency Management Agency Website. http://www.fema.gov/media-library-data/20130726-1828-25045-0014/cpg_101_comprehensive_preparedness_guide_developing_and_maintaining_emergency_operations_plans_2010.pdf. Published November 2010. Accessed November 16, 2015.